1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Item 2 FilmG212 3-28-57 et

2135

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02457

Reg. Dist. No. 74

1. PLACE OF DEATH

COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Plaza Manor Conv. Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Howard

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup 13 x 22

STREET ADDRESS (If rural give location) Box 29

3. NAME OF DECEASED (Type or Print) (First) WILBUR (Middle) (Last) ALLEN

4. DATE OF DEATH (Month) Mar (Day) 8 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	C	SINGLE	Unknown	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
General Laborer		Anne Arundel Co Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Agnes Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		[illegible]	Dorothy Brown Jessup, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Coronary Thrombosis

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic heart disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Urinary tract infection

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1956, to Mar 8, 1957, that I last saw the deceased alive on Feb 20, 1957, and that death occurred at 7 10p M, from the causes and on the date stated above.

SIGNATURE Joseph Taber M.D. ADDRESS (Street, city, town, state) 102 Balto-Annap Blvd N.E. Glen Burnie Md DATE SIGNED 3-8-57

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar 15 1957	St. Marks	Anne Arundel Co Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAR 15 1957	L. J. Selby	Ridgly Selby	Laurel, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02458

2444 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY Anne Arundel. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Round Bay Md. x2
d. STREET ADDRESS River Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Hugh. Middle: Last: Auld Jr
4. DATE OF DEATH Month: March Day: 15 Year: 1957.

5. SEX M.
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 8, 1898
9. AGE (In years last birthday) 59 yrs.
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman.
10b. KIND OF BUSINESS OR INDUSTRY Automobile Bus.
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Hugh Auld Sr.
14. MOTHER'S MAIDEN NAME Elizabeth Woods.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-01-1836
17. INFORMANT Address: wife Lois Auld Round Bay Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial INFarction
420.1
DUE TO (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 3-14-57., 19____, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Hahn M.D. ADDRESS (Street, city or town, state) Severna Park Md. DATE SIGNED 3-15-57.
PHYSICIAN'S NAME (Type) Robert R. HAHN. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/18/57
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.
22d. LOCATION (City, town, or county) (State) Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fretener & Sons. ADDRESS Balto Md
24a. REC'D BY REGISTRAR DATE 3/12/57
24b. REGISTRAR'S SIGNATURE Wm J. Frenchs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02459

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pumphrey
c. LENGTH OF STAY IN 1b: 14 y.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5930 Bellegrove Rd.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Same — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Same
d. STREET ADDRESS: 1 Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Roberstson — Last: Avery

4. DATE OF DEATH: Month: March — Day: 23rd. — Year: 19 57

5. SEX: M

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/11/05

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed in selling ice.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Gastonia, Georgia.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Avery

14. MOTHER'S MAIDEN NAME: Mary Bartlow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-6920

17. INFORMANT Address: Mrs. Helen Avery, (wife).

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert MD M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/23/57

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-27-57
22c. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
22d. LOCATION (City, town, or county) (State): A.A.Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Isaiah L. Brown and Son, 108. W. Montgomery
24a. REC'D BY REGISTRAR DATE: MAR 28 1957
24b. REGISTRAR'S SIGNATURE: Ida Whitson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the C... Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIREC... Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to ... cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02460

2445 CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 117 Monticello Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle A — Last BASIL
4. DATE OF DEATH: Month 3 — Day 16 — Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 30, 1891
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William J. Flood
14. MOTHER'S MAIDEN NAME: Mary A. Ruthard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-30-4844B
17. INFORMANT: Charles F. Basil — Address: Husband — same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Hours.
DUE TO (b): Heart failure — 2 wks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Carcinoma rectum, widely met. 1 yr.
154 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1956 to 3/16, 1957 that I last saw the deceased alive on 3/16, 1957 and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stuart M. Christhilf M.D. — ADDRESS (Street, city or town, state): 69 Franklin — DATE SIGNED: 3/17/57

PHYSICIAN'S NAME (Type): Stuart M. Christhilf Jr MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-20-57
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping Funeral Home Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAR 20 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02461

2488 **CERTIFICATE OF DEATH**

Item 7 FilmG212 3-26-57 et

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONV. HOME

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 3 Vol. 4
STREET ADDRESS (If rural give location) 348 Cammel St.

3. NAME OF DECEASED (Type or Print) (First) NETTIE (Middle) (Last) BELL

4. DATE OF DEATH (Month) Mar (Day) 10 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	C	Single	Feb. 15, 1901	56 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Balto Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Wynn	unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Martend Massey 208 Carroll Ave

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

420.0 IMMEDIATE CAUSE (A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO (B) Congestive heart failure

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic arthritis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ——, 19..., to Mar 10, 1957, that I last saw the deceased alive on ——, 19..., and that death occurred at 9:50 A.M., from the causes and on the date stated above.

SIGNATURE Joseph Tabor M.D. **ADDRESS** (Street, city, town, state) 102 Balto. Annap. Blvd Glen Burnie Md. **DATE SIGNED** Mar 10, 1957

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/21/57	Mt. Calvary Cem.	A.A. County Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
3/20/57	L.J. Dealba	A. Halstead	918 Druid Hill Ave

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02462

2449

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

LENGTH OF STAY (in this place): 13 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendship

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) GERMAN (Middle) L (Last) BOWEN

4. DATE OF DEATH: (Month) March (Day) 17 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Oct. 30, 1886	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer	Own Farm	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Benjamin Bowen	Florence Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	no	213-36-3401	Mrs Alen Wood- Prince Frederick, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Ac + Chr - Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 36 hr.

422.1 ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerotic CVD — yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. uremia due to B.P.H. — 5 yr.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4/, 1957, to 3/17/, 1957, that I last saw the deceased alive on 3/16/, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above. 3/17/57

SIGNATURE: Frank M. Shipley M.D. — ADDRESS (Street, city, town, state): 63 College Ave Annapolis — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 20, 57	Wesley Cemetery	Prince Frederick, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE Mar. 14, 57		W.H. Hutchens	Owings, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02463

2489 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights
c. LENGTH OF STAY IN 1b 6 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 Forest View Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Ar. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights R.D. 1
d. STREET ADDRESS 410 Forest View Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MARIAN Middle COLE Last BRANDT

4. DATE OF DEATH Month March Day 13 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan 15. 1876
9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life), even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Muse
14. MOTHER'S MAIDEN NAME Isabella Ursula

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service) /
16. SOCIAL SECURITY NO. /
17. INFORMANT Address Grace B. Stauffer 410 Forest View Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 1 year
420.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1956, to March 13, 1957, that I last saw the deceased alive on 3-13, 1957, and that death occurred at 3.50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE P. J. Grimaldi M.D. ADDRESS (Street, city or town, state) 4609 Ritchie Highway DATE SIGNED 3-13-57
PHYSICIAN'S NAME (Type) P. J. GRIMALDI Baltimore 25 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 16-1957
22c. NAME OF CEMETERY OR CREMATORY Western
22d. LOCATION (City, town, or county) (State) Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE John A. Teipel ADDRESS 5311 Edmondson Ave
24a. REC'D BY REGISTRAR DATE MAR 15 57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02464

2490 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis R.F.D. 4
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis R.F.D. 4 Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norman — Middle: E. — Last: Bruce Sr.

4. DATE OF DEATH: Month: 3 — Day: 10 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-8-1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Mechanical

11. BIRTHPLACE (State or foreign country): A A Co Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Silphman Bruce

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Stinecomb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Norman E. Bruce Jr. — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b): Arteriosclerotic generalized — 1 yr
DUE TO (c):

332 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1956 to March 10, 1957 that I last saw the deceased alive on 3-9-1957, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.
ADDRESS (Street, city or town, state): 6 SHAW ST ANNAPOLIS, MD.
DATE SIGNED: 3/11/57
PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar-12-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: MAR 12 1957
24b. REGISTRAR'S SIGNATURE: H. C. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2491 Item 1 Film 213 4-3-57 et

02465

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Point Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Against the jetty

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03x02 Baltimore
d. STREET ADDRESS: 2123 Sparrows Point Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Jimmie — Middle Myers — Last Campbell

4. DATE OF DEATH: Month March — Day 22 — Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/28/28

9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUS DRIVER

10b. KIND OF BUSINESS OR INDUSTRY: TRANSIT

11. BIRTHPLACE (State or foreign country): Standford, West Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HENRY CAMPBELL

14. MOTHER'S MAIDEN NAME: NINA COFFEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: FAMILY — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH:
929.9
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William Wyatt M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 3-23-57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MARCH 24, 1957
22c. NAME OF CEMETERY OR CREMATORY: FORT HILL MEM PARK
22d. LOCATION (City, town, or county) (State): LYNCHBURG VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: WHITTEN FUNERAL HOME INC. LYNCHBURG, VA.

24a. REC'D BY REGISTRAR DATE: MAR 26 1957

24b. REGISTRAR'S SIGNATURE: A. H. Hedrick

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [illegible] Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2492 **CERTIFICATE OF DEATH**

02466

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): A.A. County
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PLAZA MANOR CONV. HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3Y01.4
d. STREET ADDRESS: 1509 Lemon ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle Lost CARROLL

4. DATE OF DEATH: Month Mar Day 23 Year 1957

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 14, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Carroll

14. MOTHER'S MAIDEN NAME: Margret Fletcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: George Carroll Address: Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBROVASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH

331x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCEROSIS GENERAL
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 13, 1957, to Mar 23, 1957, that I last saw the deceased alive on Mar 19, 1957, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Taler M.D. ADDRESS (Street, city or town, state): 102 Balto-Annap. Blvd. N.E. DATE SIGNED: 3-25-57

PHYSICIAN'S NAME (Type): JOSEPH TALER Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-29-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. G. Jackson ADDRESS: Funeral Home - 916 Penna. Ave

24a. REC'D BY REGISTRAR DATE: MAR 27 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dealley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 212 3-18-57 amg

02467

2447 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: DOA Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rural Annapolis
d. STREET ADDRESS: 1 Rt 4 Box 466
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ~~ELLEN~~ ELEANOR — Middle CASE — Last (CASE)

4. DATE OF DEATH: Month March — Day 8 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 25, 1955
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months 11 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Atlanta, Georgia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Case
14. MOTHER'S MAIDEN NAME: Ethle Mae Riscalla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): none — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: William H. Case- Father- — Address: same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration of vomitus
921.0
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Upper respiratory infection

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Regurgitated food and aspirated while asleep on couch

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: 11 3/8/57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Annapolis A. A. Md.

21. I certify that I attended the deceased from 3-8-57, 19____, to 3-8-57, 19____, that I last saw the deceased alive on 3-8-57, 19____, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil H. Sims, M.D. — ADDRESS (Street, city or town, state): 95 Cathedral St — DATE SIGNED:

PHYSICIAN'S NAME (Type): NEIL H. SIMS — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-9-57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince George County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24c. RECD BY REGISTRAR DATE: MAR 11 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02468

CERTIFICATE OF DEATH

2493

Reg. Dist. No. 26

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville

LENGTH OF STAY (in this place) 1 week

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sanns Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland — COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

STREET ADDRESS (If rural give location) 2062 West Street

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) SAMUEL (Last) COALE

4. DATE OF DEATH (Month) MARCH (Day) 21 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	March 7, 1878	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Own Farm	Prince George County, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas E. Coale	Willie Suit

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	- - - -	Mrs Mildred Thompson- Daughter- Bowie, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Generalized Arteriosclerosis

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 19, 1957, to Mar 21, 1957, that I last saw the deceased alive on Mar 19, 1957, and that death occurred at 5:20 M, from the causes and on the date stated above.

SIGNATURE Edward J. Chenault M.D. — **ADDRESS** (Street, city, town, state) Lothian Md — **DATE SIGNED** 3-21-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-23-57	Mt. Zion Methodist Cemet.	Lothian, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE MAR 22 1957	E. M. Joyce	HOPPING FUNERAL HOME	Annapolis, Md.

RECEIVED

MAR 22 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2494

02469

Reg. Dist. No. 27

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade

LENGTH OF STAY (in this place): 4 hrs 23 min

HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton

STREET ADDRESS (If rural give location): Fort Meade Cabins

3. NAME OF DECEASED (Type or Print): (First) LINDA (Middle) GAIL (Last) COWARD

4. DATE OF DEATH (Month) (Day) (Year): March 18 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Single	17 March 1957	yrs.		4 / 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ralph Eldridge Coward	Joyce Marie Doigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Father, Fort Meade Cabins, Odenton, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X IMMEDIATE CAUSE (A) Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs 23 min

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 Mar 57 to 18 Mar 57, that I last saw the deceased alive on 18 Mar 57, and that death occurred at 1:50 AM, from the causes and on the date stated above.

SIGNATURE JOSEPH B. BRILL, MD — Joseph B. Brill — 0150 AM — ADDRESS (Street, city, town, state): M.D. USAH, Fort G. G. Meade, Md. — DATE SIGNED: 18 March 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	#3.31.57	Baltimore National	Balto Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 18 Mar 57	W.L.SAYLOR, 1ST LT, MSC	Wm. Cook Inc.	1217 St. Paul Street Balto 2

2050243XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2448 CERTIFICATE OF DEATH

Reg. Dist. No. 02470

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Annapolis
d. STREET ADDRESS Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First OSCAR Middle Vaughan Last DAWES.
4. DATE OF DEATH Month 3-11-57 Day Year 19

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 25, 1892
9. AGE (In years last birthday) 65 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardware Merchant
10b. KIND OF BUSINESS OR INDUSTRY Hardware
11. BIRTHPLACE (State or foreign country) Annapolis
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME John Meredith Dawes
14. MOTHER'S MAIDEN NAME W. Amanda Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) U.S. Army 1918
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT Address wife Mrs Marion Dawes

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial INFarction
177X
DUE TO (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Carcinoma Prostate c Extension
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
420.1
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19____, to 1957, 19____, that I last saw the deceased alive on 3-10-57, 19____, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Hahn M.D. ADDRESS (Street, city or town, state) Severna Park DATE SIGNED 3-11-57

PHYSICIAN'S NAME (Type) Robert R. HAHN Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-14-1957
22c. NAME OF CEMETERY OR CREMATORY St Annes Cemetery
22d. LOCATION (City, town, or county) Annapolis (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md
24a. REC'D BY REGISTRAR DATE MAR 12 1957
24b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1,9 Film C212 3-15-57 et

02471

Reg. Dist. No. 77

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fort Meade Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Jessups
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Frank Middle W. Last Dawson

4. DATE OF DEATH: Month 3 Day 2 Year 1957

5. SEX: MALE white
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 8, 1893
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM FRANK DAWSON
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Fort Meade Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William Wyatt M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 3-3-57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-5-57
22c. NAME OF CEMETERY OR CREMATORY: Dorchester Mem. Park
22d. LOCATION (City, town, or county) (State): Cambridge Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: LeCompte Funeral Home
LeCompte Funeral Home Cambridge Md.
24a. REC'D BY REGISTRAR DATE 3/6/57
24b. REGISTRAR'S SIGNATURE: Clara Phillips

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary in completing the cause of death, please enter the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2449 CERTIFICATE OF DEATH

02472

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS.
c. LENGTH OF STAY IN 1b: 14 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GEN.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 SUNRISE BEACH
d. STREET ADDRESS: 1833 POPLAR DR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY — Middle M — Last DODA

4. DATE OF DEATH: Month MARCH — Day 25, — Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-8-19

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWF.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: RALPH SCHUYLER

14. MOTHER'S MAIDEN NAME: LORETTA ASH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mary Ella Cook — Address: Queenstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY TUBERCULOSIS — INTERVAL BETWEEN ONSET AND DEATH: ?
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 22 1957, to March 25, 1957, that I last saw the deceased alive on March 25, 1957, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F. Klawans, M.D. — ADDRESS (Street, city or town, state): 31 Sentinel Rd Tel — DATE SIGNED: 3/28/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 30

22c. NAME OF CEMETERY OR CREMATORY: Centreville

22d. LOCATION (City, town, or county) (State): Centreville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: Church Hill Md.

24a. REC'D BY REGISTRAR — DATE: APR 2 1957

24b. REGISTRAR'S SIGNATURE: Jno. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG213 4-8-57 et

02473

2450 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): annapolis
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater R xo
d. STREET ADDRESS: Box 4531
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Estelle — Last: Donnell

4. DATE OF DEATH: Month: 3 — Day: 26 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2/18/08

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Cumberstone Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm. Neale

14. MOTHER'S MAIDEN NAME: Hattie Foote

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: John W. Donnell Box 453 Edgewater Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Hypertension & arteriosclerosis
DUE TO (c):

331x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-21-57, 19____, to 3-26-57, 19____, that I last saw the deceased alive on 3-25-57, 19____, and that death occurred at 5:10 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A T Allen M.D. — ADDRESS (Street, city or town, state): 64 Catholic St — DATE SIGNED: 3-30-57

PHYSICIAN'S NAME (Type): A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/2/57

22c. NAME OF CEMETERY OR CREMATORY: Chews

22d. LOCATION (City, town, or county) (State): West River Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Brown Mortuary Galesville Md

24a. REC'D BY REGISTRAR DATE: 4/3/57

24b. REGISTRAR'S SIGNATURE: W. O'Donnell

RECEIVED

APR 5 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02474

2496 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena RFD
c. LENGTH OF STAY IN 1b: 37 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mountain Rd. @ Tickneck Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena RFD
d. STREET ADDRESS: Mountain Rd. @ Tickneck Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle VIRGINIA — Last DUNLAP

4. DATE OF DEATH: Month March — Day 25 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, 1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR — Months — Days
IF UNDER 24 HRS. — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Anne ArundelCo., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Ellison

14. MOTHER'S MAIDEN NAME: Sarah E. Osborne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Samuel E. Dunlap — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ½ hour
420.1
DUE TO (b): Arteriosclerotic, Hypertensive cardio
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): vascular disease — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): generalized glandular enlargement - Carcinoma ?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 20, 19 50, to March 25, 19 57, that I last saw the deceased alive on March 24, 19 57, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): Pasadena, Md. — DATE SIGNED: Mar 25, 1957

PHYSICIAN'S NAME (Type): R.M. McLaughlin M.D. — Pasadena, Maryland — March 25/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 27/57

22c. NAME OF CEMETERY OR CREMATORY: Magothy Ch. Cem.

22d. LOCATION (City, town, or county) (State): Mountain Road, AACo., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: March 28, 1957

24b. REGISTRAR'S SIGNATURE: L J D'Alba

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND

02475

STATE DEPARTMETT OF HEALTH

2497 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Hall Beach.
LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE M.D. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Whitehall Beach.
STREET ADDRESS (If rural, give location) Annapolis Md

3. NAME OF DECEASED (Type or Print) (First) Anna. (Middle) (Last) Eggert.

4. DATE OF DEATH (Month) March (Day) 11 (Year) 57

5. SEX F.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 4 March 1868

9. AGE last birthday 89 yrs.

If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Valentine Koenig

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If year, give war or dates of service) No

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Daughter Mrs Ullmon Whitehall Beach

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

450.0 Immediate cause (a) Respiratory Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Marked Generalized Arteriosclerosis

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1955, 19....., to....., 19....., that I last saw the deceased alive on 2 March, 19 57 and that death occurred at 7 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert R Hahn ADDRESS Severna Park Md DATE SIGNED 3-11-57

23. BURIAL, CREMATION REMOVAL (Specify) Cremation

DATE Mar -14-57

NAME OF CEMETERY OR CREMATORY Ft Lincoln

LOCATION (City, town, or county) Prince George Co (State) Md

DATE REC'D BY LOCAL REG. MAR 11 1957

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02476

2451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 106 Spa View Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: A A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 105 Spa View Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Frances — Last: Ellinghausen

4. DATE OF DEATH: Month: 3 — Day: 16 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 1-1873

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: "Unk"

14. MOTHER'S MAIDEN NAME: "Unk"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Herman Ellinghausen — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular —
DUE TO
(b): Renal Disease & decompensation — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
(c):

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 12, 1955, to March 16, 1957, that I last saw the deceased alive on March 13, 1957, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Klawans, M.D. — ADDRESS (Street, city or town, state): 31 Southgate Av — DATE SIGNED: 3/16/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS, — Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-18-1957

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 18 1957

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2452

CERTIFICATE OF DEATH

02477

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7 Wardour Drive

d. STREET ADDRESS: 7 Wardour Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Edward Last: Emery

4. DATE OF DEATH: Month: 3 Day: 23 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-8-1897

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lt Col. U.S.M.C.

10b. KIND OF BUSINESS OR INDUSTRY: U.S.M.C.

11. BIRTHPLACE (State or foreign country): Brooklyn N.Y.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Livingston Emery

14. MOTHER'S MAIDEN NAME: Polly C. Pratt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes. (If yes, give war or dates of service): War I - II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorothy G. Emery (3) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Lung with
DUE TO
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized Metastasis
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 1 Yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1952 to 3-20-1957 that I last saw the deceased alive on 3-20-1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.

ADDRESS (Street, city or town, state): 6 SHAW ST. ANNAPOLIS, MD.

DATE SIGNED: 3/25/57

PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 3-27-57

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln

22d. LOCATION (City, town, or county): Prince Geo's (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: MAR 26 1957

24b. REGISTRAR'S SIGNATURE: H. U. Unruh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02478

CERTIFICATE OF DEATH

Reg. Dist. No. 24

2498

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie

LENGTH OF STAY (in this place) 6 MOS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS #3 North Meadow Drive

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Glen Burnie

STREET ADDRESS (If rural give location) #3 North Meadow Drive

3. NAME OF DECEASED (Type or Print) (First) John (Middle) LUTHER (Last) FEDDON

4. DATE OF DEATH (Month) MARCH (Day) 11 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	MARRIED	JAN 10, 1900	57 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINIST	SAME	VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Edward FEDDON	MARY VIRGINIA MOOMAW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	212-09-7821	Lou FEDDON - SAME

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 30 MIN

ANTECEDENT CAUSE(S) DUE TO (B) Coronary Thrombosis — 1 hr.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arterio Sclerotic Heart Disease — 5 YRS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Essential Hypertension — 10 YRS.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/31, 1956, to 3/11, 1957, that I last saw the deceased alive on 3/9, 1957, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE AND M.D. J W Pritchard — ADDRESS (Street, city, town, state) 715 Cotter Rd Glen Burnie Md — DATE SIGNED 3/11/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	3-14-57	TRINITY EPISCOPAL	UPPER MARLBORO, MD.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAR 14 1957	L. J. Dealley	Wallace Cookson	1211 St Paul St

MAR 14 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG212 3-26-57 et

Reg. Dist. No. 02479

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 310 Chesapeake Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT — Middle LOUIS — FISHER
4. DATE OF DEATH: Month March — Day 17 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2-1931
9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Crabs-Oysters
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles W. Fisher
14. MOTHER'S MAIDEN NAME: Lucille Monday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 1951-1954
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles W. Fisher — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Hemoperitoneum secondary to
812 X
(b): Ruptured Liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pedestrian struck by auto.
20c. TIME OF INJURY Hour: 9:35 A.M. — Month, Day, Year: 3/17 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town): Partial — (County): A.A. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Paul F. Guerin M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 3/18/57
EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar-20-1957
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: 3/19/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmC212 3-12-57 et

2454 **CERTIFICATE OF DEATH**

02480 Reg. Dist. No.

1. **PLACE OF DEATH** a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: A. A. General

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Three Mile Oak
d. STREET ADDRESS: R.F.D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Paul Middle: D. Last: Fisher

4. **DATE OF DEATH**: Month: 3 Day: 3 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-5-1905

9. AGE (In years last birthday): 52 11 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor & Builder

10b. KIND OF BUSINESS OR INDUSTRY: Homes

11. BIRTHPLACE (State or foreign country): Melford Del.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William H. Fisher

14. MOTHER'S MAIDEN NAME: Mary Towns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edna D. Fisher Address: (2)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): a. Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Artery Disease — 18 mos.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/2, 1957 to 3/3, 1957 that I last saw the deceased alive on 3/3, 1957, and that death occurred at 3:00 p. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Kirwans M.D. ADDRESS (Street, city or town, state): Annapolis, Md DATE SIGNED: 3/4/57

PHYSICIAN'S NAME (Type): MAURICE F. KIRWANS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-6-57

22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cemt

22d. LOCATION (City, town, or county) (State): Melford Del.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 3/5/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02481

2499 **CERTIFICATE OF DEATH**

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY A A — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nutwell

LENGTH OF STAY (in this place): 70 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE M D COUNTY A A

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Nutwell

STREET ADDRESS (If rural give location): 1

3. NAME OF DECEASED (Type or Print): (First) SUSAN REBECCA (Middle) (Last) FORD

4. DATE OF DEATH: (Month) 3 (Day) 25 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widow	OCT 9 1872	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Prince Georges Co Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse TROTT

14. MOTHER'S MAIDEN NAME: Barbara Ann WILKERSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ~~None~~

17. INFORMANT & ADDRESS: Annie S. Wilson, Tracys Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X IMMEDIATE CAUSE (A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Mar., 1957, to 25 Mar., 1957, that I last saw the deceased alive on 25 Mar., 1957, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE AND M.D.: J B Ranner — ADDRESS (Street, city, town, state): Upper Marlboro Md — DATE SIGNED: 26-3-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/28/57	Friendship	Friendship MD

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAR 28 1957	[signature]	Bernard Hardesty	Hyattsville Md

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02482

CERTIFICATE OF DEATH

(2500

Reg. Dist. No. 27

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT Geo. G. MEADE, MD. — LENGTH OF STAY (in this place) 4 HOURS

HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE ~~MARYLAND~~ VIRGINIA COUNTY ~~Anne Arundel~~ Norfolk

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Fort Geo. G. Meade, Md.~~ Norfolk 83X-3

STREET ADDRESS (If rural give location) 3315 Kansas Avenue ~~1565 Carvel Ave.~~

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JANET	LEE	FRANCIS	3	11	1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W		3/11/57	— yrs.	—		4	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
RICHARD W. FRANCIS	BERNICE C. PUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
—	—	—	FATHER, 1565 CARVEL AVE, MD. FORT MEADE,

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

776X IMMEDIATE CAUSE (A) Prematurity — 4 HOURS

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—	—	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
		—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
		—

22. I hereby certify that I attended the deceased from 11 Mar., 19 57, to 11 Mar., 19 57, that I last saw the deceased alive on 11 Mar., 19 57, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

SIGNATURE THOMAS A. COOK, JR. MD — M.D.

ADDRESS (Street, city, town, state) U.S. ARMY HOSPITAL, FORT Geo. G. MEADE, MD.

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	Mar. 12, 1957	Balto. Natl	Baltimore Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
3/11/57	WILLIAM L. SAYLOR, 1st H	WM COOKE, INC.	Baltimore, Maryland

2050252XVO

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

M C I

02501

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02483

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: ~~Maryland~~ PENNSYLVANIA — COUNTY: ~~Prince Georges~~ Clearfield

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Laurel~~ DuBois 75 X-3

STREET ADDRESS (If rural give location): ~~114 W. 2nd Avenue Laurel Park Hotel~~

3. NAME OF DECEASED (Type or Print): DONN (First) DOUGLAS (Middle) FRENCH (Last)

4. DATE OF DEATH: March (Month) 18 (Day) 19 57 (Year)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	17 March 1957	yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Gary Neil French, Sr.	Dorothy Jean Cable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Father, Laurel Park Hotel, Laurel, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 IMMEDIATE CAUSE (A) Anoxia Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 12 hours (est.)

ANTECEDENT CAUSE(S) DUE TO (B) Atelectasis Atelectasis — 33¾ hours

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Immaturity Immaturity — 33¾ hours

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. **I hereby certify** that I attended the deceased from 17 March, 1957, to 18 March, 1957, that I last saw the deceased alive on 18 March 1957, and that death occurred at 5:47 P.M., from the causes and on the date stated above.

SIGNATURE RICHARD M. MCGUANE, Capt, MC — 0547PM — **ADDRESS** (Street, city, town, state) 2101-150, USAH, Ft Meade Md — **DATE SIGNED** 18 Mar 57

Richard M. McGuane M.D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	3.21.57	Morningside	Dubois Pa.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 19 Mar 57	W.L.SAYLOR, 1ST LT, MSC	Wm. Cook Inc.	1217 ST. PAUL STREET

2050192 XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02502 Items 9, 14 FilmG214 4-18-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest Middle: Green Last:
4. DATE OF DEATH: Month: 3 Day: 8 Year: 1957
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-3-1879
9. AGE (In years last birthday): 77 78 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Davidsonville
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Samuell Green
14. MOTHER'S MAIDEN NAME: Bessie Robinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Failure, Cardiac — INTERVAL BETWEEN ONSET AND DEATH:
434.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-9-57, 19____, to 3-16-57, 19____, that I last saw the deceased alive on 2-16-57, 19____, and that death occurred at 12:25 M, from the causes and on the date stated above.
ACTUAL SIGNATURE: A T Allen M.D. ADDRESS (Street, city or town, state): 61 Cathedral St DATE SIGNED: 3-9-57
PHYSICIAN'S NAME (Type): A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-11-57
22c. NAME OF CEMETERY OR CREMATORY: Davidsonville
22d. LOCATION (City, town, or county) (State): Davidsonville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: William Kenney ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAR 14 1957
24b. REGISTRAR'S SIGNATURE: Carrie Sullo

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2455 CERTIFICATE OF DEATH

02485

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel Gen. Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md 10
d. STREET ADDRESS: 3 Maryland Ave 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GRACE Middle Last HART

4. DATE OF DEATH: Month MARCH Day 11 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): About 63 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? GREAT BRITAIN

13. FATHER'S NAME: Walter H. Heart

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Gaither + Bald (Lawyers) Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer, st. ovary c generalized — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Metastasis
DUE TO (c):

175 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/27, 1957, to 3/11, 1957, that I last saw the deceased alive on 3/11, 1957, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Klawans M.D. — ADDRESS (Street, city or town, state): 3, SOUTHGATE AVE., — DATE SIGNED

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS, M.D. — ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: MARCH 12-1957

22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN

22d. LOCATION (City, town, or county) (State): PRINCE GEORGES Co MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John M Taylor Sr Annapolis Maryland

24a. REC'D BY REGISTRAR DATE: 3/14/57

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02486

2456 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7 Constitution Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 7 Constitution Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle William — Last Heller

4. DATE OF DEATH: Month March — Day 20 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 6 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipefitter

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Heller

14. MOTHER'S MAIDEN NAME: Dorathea Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Anthony W. Howes — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
(b): Arteriosclerosis generalized — 1 yr.
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 19 55, to March 20 19 57 that I last saw the deceased alive on March 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.

ADDRESS (Street, city or town, state): 6 SHAW ST. ANNAPOLIS, MD.

DATE SIGNED: 3/24/57

PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-23-57

22c. NAME OF CEMETERY OR CREMATORY: St Mary's

22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: MAR 22 1957

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2457 CERTIFICATE OF DEATH

Reg. Dist. No. 02487

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 16 Severn Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry — Middle Elmer — Last Henneberger
4. DATE OF DEATH: Month 3 — Day 7 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 28th 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator
10b. KIND OF BUSINESS OR INDUSTRY: Painting Etc
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Henry Henneberger
14. MOTHER'S MAIDEN NAME: Mary Demitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Florence Henneberger — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Ignition	2 mos.
DUE TO (b)	Cerebral Hemorrhage	2 mos.
DUE TO (c)	Cerebral Arteriosclerosis	unknown

331.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1955, to 7 MAR. 1957, that I last saw the deceased alive on 4 MAR. 1957, and that death occurred at 6 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave — DATE SIGNED: 3/10/57
PHYSICIAN'S NAME (Type): EDWARD S. BECK MD — ANNAPOLIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-11-57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county): Glen Burnie (State): Md
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS:
24a. REC'D BY REGISTRAR DATE: MAR 11 1957
24b. REGISTRAR'S SIGNATURE: [illegible] U. Council

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2458 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02488

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH — a. COUNTY: A A — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) — a. STATE: Md — b. COUNTY: A A
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A A General — 63
d. STREET ADDRESS: 1 Marda Lane — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First E. — Middle Roland — Last Hopkins
4. DATE OF DEATH: Month 3 — Day 14 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug-31-1902
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber — I 1
10b. KIND OF BUSINESS OR INDUSTRY: Plumber
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Edgar E. Hopkins
14. MOTHER'S MAIDEN NAME: Mary Hyde
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): — 0
16. SOCIAL SECURITY NO.:
17. INFORMANT: Irma A. Hopkins — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1
DUE TO (b): Coronary Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3-14-57
EXAMINER'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-17-57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie Md
23. FUNERAL DIRECTOR'S SIGNATURE: John W. Layton Sons — ADDRESS: Annapolis Md.
24c. REC'D BY REGISTRAR DATE: MAR 18 1957
24b. REGISTRAR'S SIGNATURE:

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02489

2459 CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Anne Arundel~~ Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hosptial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Housley Rd. (Rural)
d. STREET ADDRESS: 1 RFD Annapolis,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle HOUSLEY Last
4. DATE OF DEATH: Month March Day 4 Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 8, 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Brickmason
10b. KIND OF BUSINESS OR INDUSTRY: ~~sself~~ employed
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Housley
14. MOTHER'S MAIDEN NAME: Ellen West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital record office — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial infarction	2 wks.
DUE TO	420.1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary artery atherosclerosis	10 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/20, 19 57, to 3/4, 19 57, that I last saw the deceased alive on 3/4, 19 57, and that death occurred at 5:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Hedeman M.D. — ADDRESS (Street, city or town, state): 90 Cathredral Street Annapolis, Md. — DATE SIGNED: 3/4/57

PHYSICIAN'S NAME (Type): John Hedeman MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 7, 57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 8 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

RECEIVED

MAR 8 1957

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02503 CERTIFICATE OF DEATH

Reg. Dist. No. 02490

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4yrs.4mos.27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 Vol-4
d. STREET ADDRESS: Not given
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Arianna — Middle: — Last: Howard

4. DATE OF DEATH: Month: March — Day: 26 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 76? yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH

153X

DUE TO (b): Carcinoma of large bowel

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/25, 1948, to 3/26, 1957, that I last saw the deceased alive on 3/25, 1957, and that death occurred at 3:15a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Benedict M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 3/26/57

PHYSICIAN'S NAME (Type): L. Benedict

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremated

22b. DATE THEREOF: 3-28-57

22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Medical School

22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Lease, Jr. — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 4/1/57

24b. REGISTRAR'S SIGNATURE: E. M. Jayne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02491

2460 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
d. STREET ADDRESS: 218 N. Taylor Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THELMA Middle E Last JACKSON

4. DATE OF DEATH: Month March Day 23 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Dec. 22, 1912
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Retail Drug Store
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arthur Benchoff
14. MOTHER'S MAIDEN NAME: Lulu Delphey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 226-36-8830
17. INFORMANT: Mrs. Lulu Benchoff - Mother- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 330 x Rupture of aneurysm of Circle of Willis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/22/57, 19 57 to 3/22/57, 19 57 that I last saw the deceased alive on 3/22/57, 19 ____, and that death occurred at 11:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 3/25/57

PHYSICIAN'S NAME (Type): Frank M. Shipley MD — 63 College Ave Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3- 26-47
22c. NAME OF CEMETERY OR CREMATORY: Dedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR: MAR 27 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02492

2461 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 21 Monroe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Albert Middle Last Jacobs
4. DATE OF DEATH Month 3 Day 17 Year 1957
5. SEX Male
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-13-1880
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Waterbury, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nathaniel Jacobs
14. MOTHER'S MAIDEN NAME Louise Hacala

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 216-16-8220
17. INFORMANT Marie Bradford Address Annap. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH
492X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-16-57, 19____, to 3-16-57, 19____, that I last saw the deceased alive on 3-16-57, 19____, and that death occurred at 7:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE A T Allen M.D. ADDRESS (Street, city or town, state) 69 Cathedral DATE SIGNED 3-17-57

PHYSICIAN'S NAME (Type) A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-20-57
22c. NAME OF CEMETERY OR CREMATORY St. Mary's
22d. LOCATION (City, town, or county) (State) Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE MAR 19 1957
24b. REGISTRAR'S SIGNATURE Jm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02504 **CERTIFICATE OF DEATH**

02493

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Arundel Beach Road.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same x2
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle Zachriah Last Jacobs

4. DATE OF DEATH: Month March Day 7th. Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/26/87

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lanscape artist.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewin Henry Jacobs

14. MOTHER'S MAIDEN NAME: Margeret Dressel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): World War # 1 Infantry.

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Maude Jacobs (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

443x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive cardio vascular diseases — ?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 6, 1957, to March 7, 1957, that I last saw the deceased alive on 3/6/57, 19, and that death occurred at 4.15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H Faubert M.D. ADDRESS (Street, city or town, state): Glen Burnie, Md. DATE SIGNED: 3/7/57

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/11/57

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.

22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: JOHN F. DENNY, INC. 715 Light St. Baltimore-30, Md.

24a. REC'D BY REGISTRAR DATE: MAR 12 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dealba

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2462 CERTIFICATE OF DEATH

02494
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A A. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 153 Fleet
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helen — Middle M. — Last Jernigan
4. DATE OF DEATH: Month 3 — Day 9 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-24-1905
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Ambrose Hubbard
14. MOTHER'S MAIDEN NAME: Blankenown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Blanche Drury — Address: Jambills Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.
DUE TO (b): Hypertensive Cardio Vascular disease — 1 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-9-, 1957 to 3/9/, 1957, that I last saw the deceased alive on 3-9-, 1957, and that death occurred at 1:14 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin, M.D. — ADDRESS (Street, city or town, state): 6 SHAW ST ANNAPOLIS, MD. — DATE SIGNED: 3/11/57
PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-13-57
22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: MAR 12 1957
24b. REGISTRAR'S SIGNATURE: C. Emmert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2463

CERTIFICATE OF DEATH

02495

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberstone x2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Tyrone — Middle: S — Last: Johnson

4. DATE OF DEATH: Month: 3 — Day: 16 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-13-57
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George Johnson
14. MOTHER'S MAIDEN NAME: Alice Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: George Johnson — Address: Cumberstone, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia / Lung — INTERVAL BETWEEN ONSET AND DEATH:
163X
DUE TO
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-26-57, 19 to 3-16-57, 19, that I last saw the deceased alive on 3-14-57, 19, and that death occurred at 5:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Allen — M.D.
ADDRESS (Street, city or town, state): 62 Cathedral St
DATE SIGNED: 3-16-57
PHYSICIAN'S NAME (Type): A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-19-57
22c. NAME OF CEMETERY OR CREMATORY: Hopes Chapel
22d. LOCATION (City, town, or county) (State): Edgewater Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Lee T. — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAR 19 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Trenchs

2039278XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02496

02505

CERTIFICATE OF DEATH

Item 9 FilmG212 3-15-57 et

Reg. Dist. No. 76 51

1. PLACE OF DEATH

COUNTY AA — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jewell md

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY AA

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jewell, md.

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frank	N.	Jones.	3	6.	1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
m	C		Aug-10-1902.	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer.		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Jones	Mary Reid.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	577-20-5630	Pauline Jones. Jewell md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X IMMEDIATE CAUSE (A) Adenocarcinoma rectosigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSE(S) DUE TO (B) & Metastasis.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Multiple Polyps of Colon — ?4

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-28, 1957, to 23 Feb, 1957, that I last saw the deceased alive on 23 Feb, 1957, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE: I D Hendricks M.D. — ADDRESS (Street, city, town, state): Shady Side, Md — DATE SIGNED: 3-7-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
		Union Chapel A A Co	Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 3-9-57	H. W. Ward	P. E. Sewell.	Prince Frederick Md

Ida Belle Dentz

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG212 3-15-57et

02506

02497

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2yrs.2mos.5days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3V01-4
d. STREET ADDRESS: 652 Vine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas; Middle; Last Jones

4. DATE OF DEATH: Month 3; Day 5; Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Jones

14. MOTHER'S MAIDEN NAME: Eliza Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 72 hours
522X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocardial Infarction, Arteriosclerosis, CVD, Decubiti

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/30/54, 19____, to 3/5/57, 19____, that I last saw the deceased alive on 3/4, 1957, and that death occurred at 4:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 3/5/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/10

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem

22d. LOCATION (City, town, or county) (State): Chester Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Corbell — ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 8 1957

24b. REGISTRAR'S SIGNATURE: H. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02498

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 1-1957-3-20-57

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST HYATTSVILLE

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen Hosp
d. STREET ADDRESS: 2611 Nicholson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard Middle R. Last LARRICK
4. DATE OF DEATH: Month MARCH Day 20 Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 23, 1875
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store clerk
10b. KIND OF BUSINESS OR INDUSTRY: General Store
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James S. Larrick
14. MOTHER'S MAIDEN NAME: Nannie Showalter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ? (If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: Richard Larrick- Son- West Friendship, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SENILITY; ARTERIOSCLEROTIC CARDIO —
DUE TO: VASC. DIS & Hypertension, AURICULAR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): FIBRILLATION, MYOCARDIAL INFARCTION
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fx LT TIBIA; Concussion & Possible Bulbar Damage

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AUTO ACCIDENT
20c. TIME OF INJURY Hour: 4:30 (p. m.) Month, Day, Year: 1-19 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): STREET
20f. (City or town) Woodland Beach (County) Anne Arundel (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W E Landmesser M.D.
EXAMINER'S NAME (Type): W.E. LANDMESSER JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒ pro Tem
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 3-20-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-23-57
22c. NAME OF CEMETERY OR CREMATORY: Ivy Hill Cemetery
22d. LOCATION (City, town, or county) (State): Upperville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Hopping Funeral Home Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 22 1957
24b. REGISTRAR'S SIGNATURE: Jm. J. Fuchs

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02507 **CERTIFICATE OF DEATH** 02499

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Selby Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater X 2
d. STREET ADDRESS: Selby Blvd. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Washington — Last: Lindsay

4. DATE OF DEATH: Month: 3 — Day: 29 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1 May 1881

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairyman

10b. KIND OF BUSINESS OR INDUSTRY: Chestnut Farms

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grace Lindsay

14. MOTHER'S MAIDEN NAME: Martha Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 578035190

17. INFORMANT: Martha Jones — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure
DUE TO
(b): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 ½ months
DUE TO
(c):

434.1
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 10, 1956, to March 29, 1957, that I last saw the deceased alive on Dec 29, 1956, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D.
ADDRESS (Street, city or town, state): RFD #1 Box 277-M Edgewater, Maryland
DATE SIGNED: 3/29/57
PHYSICIAN'S NAME (Type): Sylvia M. Lim M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-1-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Fasciska Sons
ADDRESS: Hyattsville, Md.
24c. REC'D BY REGISTRAR DATE: APR 2 1957
24d. REGISTRAR'S SIGNATURE: Wm J. Fasciska

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

578-03-5190

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2465 CERTIFICATE OF DEATH

Reg. Dist. No. 02500

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 148 Gloucester St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 148 Gloucester St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Katherine Middle E. Last Linthicum

4. DATE OF DEATH: Month March Day 14 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 4, 1876
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: City Gov't.
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David O. Parlett
14. MOTHER'S MAIDEN NAME: Mary Louise Knight.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Thomas J. Linthicum III (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — Interval between onset and death: Suffrin
DUE TO (b): Hypocondritis — Some Month
DUE TO (c): Cerebral Arteriosclerosis — Several Yrs.

422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-7, 1957, to 3-14, 1957, that I last saw the deceased alive on 3-14, 1957, and that death occurred at 11 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. ADDRESS (Street, city or town, state): 40 Franklin St, Annapolis, Md. DATE SIGNED: 3/16/57

PHYSICIAN'S NAME (Type): J. OLIVER PURVIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-17-1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Son ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR / DATE: MAR 18 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02508 CERTIFICATE OF DEATH

03632

Reg. Dist. No. 2[illegible]

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
LENGTH OF STAY (in this place) 13 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School Children's Center

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D. C. 47x-3
STREET ADDRESS (If rural give location) 1220 Delaware Ave. S.W.

3. NAME OF DECEASED: (Type or Print) (First) Mildred (Middle) (Last) Lowe

4. DATE OF DEATH: (Month) March (Day) 7 (Year) 1957

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: Jan. 17, 1929
9. AGE last birthday 28 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): inmate
10B. KIND OF BUSINESS OR INDUSTRY: institution
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lonnie Lowe
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS: Social Service Records Children's Center, Laurel, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

753.1 IMMEDIATE CAUSE (A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) congenital cerebral anomaly — 28 yrs.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. familial mental deficiency

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW OID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 1957 to 3/7, 1957, that I last saw the deceased alive on 3/2, 1957, and that death occurred at 5:45 AM, from the causes and on the date stated above.

SIGNATURE Wilfred R. Ehrmentraut — ADDRESS M.D. Children's Center Laurel, Md. — DATE SIGNED 3/9/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Mar 7-57 — NAME OF CEMETERY OR CREMATORY Childrens Center — LOCATION (City, town, or county) Laurel Md (State)

DATE REC'D BY LOCAL REGISTRAR 3-7-57 — REGISTRAR'S SIGNATURE Clara Hocshuh — 24. FUNERAL DIRECTOR Wehrmentraut — ADDRESS Laurel, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12,14 Film 0212 3-14-57 et

02599

CERTIFICATE OF DEATH

02501

Reg. Dist. No. 25

1. PLACE OF DEATH
a. COUNTY: Anne Arundel Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Md. (25)
d. STREET ADDRESS: 917 Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Lubunyz Last:

4. DATE OF DEATH: Month: March Day: 8 Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1870

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ukrainian

12. CITIZEN OF WHAT COUNTRY? Ukraine

13. FATHER'S NAME: Babiy

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Lubunyz; Address: 917 Church St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-14, 19 57, to 3-8, 19 57, that I last saw the deceased alive on 3-8, 19 57, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Eugene Schnitzer M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 3-9-57

PHYSICIAN'S NAME (Type): Eugene Schnitzer, M.D. 3904 S. Hanover St.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-12-1957

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

22d. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. S. Fialkowski ADDRESS: 2007 Eastern Ave

24a. REC'D BY REGISTRAR DATE: MAR 11 1957

24b. REGISTRAR'S SIGNATURE: Ida Hutton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02502

Reg. Dist. No. 21

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Anna Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anna Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
d. STREET ADDRESS: 5 School St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Harry — Middle Clifton — Last MacJilton
4. DATE OF DEATH: Month March — Day 8, — Year 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 6, 1899
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Clifton MacJilton
14. MOTHER'S MAIDEN NAME: Mary Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Elizabeth H. MacJilton — Address: Annapolis, Md. 5 School St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
420.1
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. Linhardt — DATE SIGNED: 3/8/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 11, 1957
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county): Baltimore, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John O. Mitchell & Sons Inc. 1900 Eutaw Pl. Balto
24a. REC'D BY REGISTRAR DATE: MAR 11 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Fuenche

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2467

CERTIFICATE OF DEATH

02503

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~AA~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Annapolis~~ 3V01.4
d. STREET ADDRESS: 1931 Edmondson Ave. Baltimore, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle: Baby Boy — Last: MARTIN

4. DATE OF DEATH: Month: March — Day: 24 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-24-57

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours: 2 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Newborn

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Robert Owen MARTIN

14. MOTHER'S MAIDEN NAME: Marilyn HUGHES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: U.S.Naval Hospital, Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity with Immaturity — INTERVAL BETWEEN ONSET AND DEATH
761.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Premature Labor
DUE TO
(c): Partial Premature separation of Placenta

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-24, 19 57, to 3-24, 19 57, that I last saw the deceased alive on 3-24-57, 19 57, and that death occurred at 4:07a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. Egan M.D.
ADDRESS (Street, city or town, state): U.S.Naval Hospital, Annapolis, Md.
DATE SIGNED: 3/24/57
PHYSICIAN'S NAME (Type): John T. Egan Cdr. MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/26/57
22c. NAME OF CEMETERY OR CREMATORY: U.S. Navy
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Otho S. Hicks
ADDRESS: 43 Northwest Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 195
24b. REGISTRAR'S SIGNATURE: [illegible]

2051193XVo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2468

02504

CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 30 mo
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
d. STREET ADDRESS: 1000 Madison St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MICHAEL — Middle (MICHAEL MARX) — Last MARX

4. DATE OF DEATH: Month MARCH — Day 1 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 16, 1879
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Prop.
10b. KIND OF BUSINESS OR INDUSTRY: Importer
11. BIRTHPLACE (State or foreign country): New York City, N.Y
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Marx
14. MOTHER'S MAIDEN NAME: Bertha Posner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs Essie Marx- Wife- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 10 MINUTES
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
260X DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1955, to March 1, 1957, that I last saw the deceased alive on March 1, 1957, and that death occurred at 10:33 P M, from the causes and on the date stated above.
ACTUAL SIGNATURE: John L. Hedeman M.D. — ADDRESS (Street, city or town, state): 90 Cathedral St. — DATE SIGNED: 3/1/57
PHYSICIAN'S NAME (Type): John Hedeman MD — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
22b. DATE THEREOF: 3-3-57
22c. NAME OF CEMETERY OR CREMATORY: Union Field Cemetery
22d. LOCATION (City, town, or county) (State): Brooklyn, New York

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR / DATE
24b. REGISTRAR'S SIGNATURE: Jm. J. Francis

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02510 **CERTIFICATE OF DEATH** 02505

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 300 Jerlyn Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: a.a.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights XO
d. STREET ADDRESS: 300 Jerlyn Avenye 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ignatius — Middle: — Last: Moog
4. DATE OF DEATH: Month: March — Day: 5 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 25, 1897
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traffic Checker
10b. KIND OF BUSINESS OR INDUSTRY: Baltimore Transit
11. BIRTHPLACE (State or foreign country): Jeannette, Pa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Joseph Moog
14. MOTHER'S MAIDEN NAME: Amm Weister
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): W.W.I (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Elsie M. Moog, 300 Jeryln Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cirrhosis of the liver — 7 yrs.
DUE TO
(c):
581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 1955, to March 5, 1957, that I last saw the deceased alive on March 2, 1957, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Milton Linthicum M.D. — ADDRESS (Street, city or town, state): 106 W. Maple Rd Linthicum — DATE SIGNED: 3/5/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-7-57
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Cook, Inc., 1217 St. Paul Street
24a. REC'D BY REGISTRAR — DATE: 3/6/57
24b. REGISTRAR'S SIGNATURE: A. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02506

02511 **CERTIFICATE OF DEATH**

Reg. Dist. No. 16

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bristol
d. STREET ADDRESS: Greenock
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle ODIE — Last MORELAND

4. DATE OF DEATH: Month MARCH — Day 30 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 31, 1874

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard F. Moreland

14. MOTHER'S MAIDEN NAME: Mary M. Stallings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-22-0606

17. INFORMANT — Address: Mrs Bernice Gibson, Bristol, Maryland (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteriosclerotic CVR Disease — 6 yrs
DUE TO (c):

4.22.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1946, to 30 Mar, 1952, that I last saw the deceased alive on 30 Mar, 1957, and that death occurred at 3 5/4 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R F B Sasscer MD M.D. — ADDRESS (Street, city or town, state): Upper Marlboro Md — DATE SIGNED: 31 Mar 57

PHYSICIAN'S NAME (Type): Robert Sasscer MD — Prince George County, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-2-57

22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery

22d. LOCATION (City, town, or county) (State): Lothian, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: APR 1 1957

24b. REGISTRAR'S SIGNATURE: Ida Belle Dent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD
c. LENGTH OF STAY IN 1b: SECONDS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BROADNECK ROAD

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 ARNOLD
d. STREET ADDRESS: 1 BELVEDERE HEIGHTS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle CHARLES — Last MULLIKIN

4. DATE OF DEATH: Month MARCH — Day 3 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-3-30

9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NEAVITT, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES M. MULLIKIN

14. MOTHER'S MAIDEN NAME: ANNA HOPE HIGGINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): 1952-53

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MRS. CLEO MULLIKIN (WIFE)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
825X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) LACERATION OF RIGHT CAROTID ARTERY AND JUGULAR VEIN — SUDDEN
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AUTOMOBILE ACCIDENT

20c. TIME OF INJURY — Hour: 5:30 a.m. p.m. — Month, Day, Year: 3-3-57 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Broadneck Road

20f. (City or town) (County) (State): Arnold, A.A., Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3-3-57

EXAMINER'S NAME (Type): GUSTAVE H. FAUBERT, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-6-1957

22c. NAME OF CEMETERY OR CREMATORY: Bosman Cemetery

22d. LOCATION (City, town, or county) (State): Bosman Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor - Sons — ADDRESS: Annapolis, Md. — DATE: MAR 2 1957

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02513 02508

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville (Severna Park)
c. LENGTH OF STAY IN 1b: 7 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jumper Hole Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena P.O. X2
d. STREET ADDRESS: Brookfield Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leroy — Middle: James — Last: Myers

4. DATE OF DEATH: Month: March — Day: 17th. — Year: 19 57

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: June 1899 — 9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Myers
14. MOTHER'S MAIDEN NAME: ? Hull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-18-7048
17. INFORMANT — Address: Mrs. Emilia Myers (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — DATE SIGNED
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ — 3/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 3/20/57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Homes - 130 E. Fort Avenue
24a. REC'D BY REGISTRAR — DATE: MAR 21 1957
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2469 CERTIFICATE OF DEATH

02509

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 11 College Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Edith — Middle C — Last Otis
4. DATE OF DEATH: Month 3-12 — Day — Year 1957
5. SEX: Female
6. COLOR OR RACE: Cl.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-1-1896
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Wise
14. MOTHER'S MAIDEN NAME: Edith Savage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriolar Nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
442X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular Dis — 4 yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-12, 1955 to 3-12, 1957 that I last saw the deceased alive on 3-12, 1957, and that death occurred at 10:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Faye Allen M.D. — ADDRESS (Street, city or town, state): 62 Cathedral St — DATE SIGNED: 3-13-57

PHYSICIAN'S NAME (Type): Faye W. Allen — 62 Cathedral St Annap Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-57
22c. NAME OF CEMETERY OR CREMATORY: Carver Memorial Pk.
22d. LOCATION (City, town, or county) (State): Laurel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAR 14 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Fuenh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2470

Reg. Dist. No. 02510

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: DOA, U. S. Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 224 Wardour Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Edward — Last: O'Neil

4. DATE OF DEATH: Month: 3 — Day: 30 — Year: 1957

5. SEX: M

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-13-50

9. AGE (In years last birthday): 7 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Oak Harbor, Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Francis O'Neil

14. MOTHER'S MAIDEN NAME: Mary Francis Mahoney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Father, James F. O'Neil — Address: (Same as 2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphixiation — INTERVAL BETWEEN ONSET AND DEATH:
936.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Strangulation by rope - neck — 5 Min. ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Patient dead on arrival - verbal information from parents - accident occurred during childhood playing.

20c. TIME OF INJURY Month, Day, Year: Hour 1 p. m. 30 March 1957

20d. INJURY OCCURRED: White at work ☐ Not white at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home-backyard

20f. (City or town) (County) (State): Annapolis Anne Arundel Md.

21. I certify that I attended the deceased from 30 March, 1957, to 30 March, 1957, that I last saw the deceased alive on DOA 30 March, 1957, and that death occurred at 1 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED

PHYSICIAN'S NAME (Type) L. A. MORALES, LCDR, MC, USNR — U.S. Naval Hospital, Annapolis, Md. 4/1/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4-2-1957
22c. NAME OF CEMETERY OR CREMATORY: U.S. NAVAL ACADEMY
22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR, SON
ADDRESS: ANNAPOLIS MD

24a. REC'D BY REGISTRAR DATE: APR 2 1957
24b. REGISTRAR'S SIGNATURE: [signature] - U.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02514

CERTIFICATE OF DEATH

02511 A

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 4yrs.40days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3701-4
d. STREET ADDRESS 905 N. Spring Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: William Middle: Last: Pearry

4. DATE OF DEATH Month: 3 Day: 10 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep.

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Not given

14. MOTHER'S MAIDEN NAME: Not given

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT Hospital Records Address: Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b) Venous Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 053.4

DUE TO (c) Septicemia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gangrene left stump (below knee amputation)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/29, 1953, to 3/10, 1957, that I last saw the deceased alive on 3/10, 1957, and that death occurred at 9:10a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.

ADDRESS (Street, city or town, state) Crownsville, Md.

DATE SIGNED 3/11/57

PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal

22b. DATE THEREOF 3-18-57

22c. NAME OF CEMETERY OR CREMATORY U. of Md. Medical School

22d. LOCATION (City, town, or county) (State) Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese II ADDRESS Annapolis, Md.

24a. REC'D BY REGISTRAR DATE 3/20/57

24b. REGISTRAR'S SIGNATURE L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02515

CERTIFICATE OF DEATH

02512
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nutwell
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Nutwell
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Richard Middle GLENN Last PROUT

4. DATE OF DEATH: Month MARCH Day 8 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/28/74

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Tobacco

11. BIRTHPLACE (State or foreign country): Choneyville Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jos. Richard Prout

14. MOTHER'S MAIDEN NAME: SUZANNA CHASE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Anna Jones Lothian Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic malignant melanoma
190X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 10, 1957, to March 8, 1957, that I last saw the deceased alive on March 7, 1957, and that death occurred at 3 00 P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED: 3/8/57

ACTUAL SIGNATURE: John L. Hedrman M.D.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/10/57

22c. NAME OF CEMETERY OR CREMATORY: Friendship

22d. LOCATION (City, town, or county) (State): Friendship Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bruce Hardesty ADDRESS: Galesville Md

24a. REC'D BY REGISTRAR DATE: 3/3/57

24b. REGISTRAR'S SIGNATURE: [illegible]

VS A15 (4)
15M 9/55

RECEIVED

MAR 14 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2471 CERTIFICATE OF DEATH

02513

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 999 Van Buren St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANTONIO Middle PUNARO Last

4. DATE OF DEATH: Month MARCH Day 25, Year 1957 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Prop
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Angelo Punaro
14. MOTHER'S MAIDEN NAME: Teresa Curcia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 253-52-3034A
17. INFORMANT: Mrs Rosa Punaro- Wife- Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 19 55, to March 25, 19 57, that I last saw the deceased alive on March 25, 19 57, and that death occurred at P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Lindhardt M.D.
ADDRESS (Street, city or town, state): 3 Chespeake Ave, Annapolis Md.
DATE SIGNED: 3/26/57
PHYSICIAN'S NAME (Type): E. Lindhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
22b. DATE THEREOF: March 29, 57
22c. NAME OF CEMETERY OR CREMATORY: Westover Memorial Cemet.
22d. LOCATION (City, town, or county) (State): Augusta, Georgia

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME
ADDRESS: Annapolis, Maryland
24a. RECD BY REGISTRAR DATE: MAR 29 1957
24b. REGISTRAR'S SIGNATURE: Jos. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02516 **CERTIFICATE OF DEATH**

02514

Reg. Dist. No. 78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland Dela. b. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville	c. LENGTH OF STAY IN 1b: 8 yrs. 2 mos. 12 days
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville 46 X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital	d. STREET ADDRESS: None listed
	e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Jimmie		Purnell	3	21	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		Not given	88? yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Not given	Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Purnell	Mary Station

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unk.	Unk.	Unk.	Hospital Records	Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Senile arteriosclerotic cardiovascular Disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/9/49, 19—, to 3/21, 1957, that I last saw the deceased alive on 3/20, 1957, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 3/21/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	3-28-57	U. of M. Medical School	Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: 4/1/57

24b. REGISTRAR'S SIGNATURE: K. M. Joyce

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02515

2472 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1480 Schley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: G. — Middle: Turner — Last: Quaid

4. DATE OF DEATH: Month: 3 — Day: 2 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-3-1902

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treas City, Annapolis

10b. KIND OF BUSINESS OR INDUSTRY: Treas City, Annapolis

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George F Quaid

14. MOTHER'S MAIDEN NAME: Louise Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.:

17. INFORMANT: HELEN E. QUAID — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Arteriosclerosis Generalized
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

INTERVAL BETWEEN ONSET AND DEATH: 2 days. / 14 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1950, to Jan. 21, 1957, that I last saw the deceased alive on 3-2-1957, and that death occurred at 2:35 p. m., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.

ADDRESS (Street, city or town, state): 6 Shaw St. Annapolis, Md.

DATE SIGNED: 3/4/57

PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-5-57

22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF

22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons

ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 3/5/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2473 Item 7 Film G212 3-22-57 et

CERTIFICATE OF DEATH

02516

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 18 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: ""
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 10
d. STREET ADDRESS: 93 - Waters Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IDA Middle "" Last QUEEN

4. DATE OF DEATH: Month MARCH Day 15 Year 1957

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ""

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months "" Days "" — IF UNDER 24 HRS.: Hours "" Min. ""

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC

10b. KIND OF BUSINESS OR INDUSTRY: MAID

11. BIRTHPLACE (State or foreign country): Kent County Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service): ""

16. SOCIAL SECURITY NO.: 218-36-3691

17. INFORMANT: Mrs. Lester Grimes Address: 214 - Genesee St, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ""

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Embolism Arteriosclerosis

DUE TO (c): ""

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 ""

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ""

20f. (City or town) "" (County) "" (State) ""

21. I certify that I attended the deceased from March 8, 1957, to March 15, 1957, that I last saw the deceased alive on March 15, 1957, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D. ADDRESS (Street, city or town, state): 110 - Clay St. Annapolis, Md. DATE SIGNED: 3/16/57

PHYSICIAN'S NAME (Type): ""

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-18-57

22c. NAME OF CEMETERY OR CREMATORY: Asbury

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Lowe Jr. ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 3/19/57

24b. REGISTRAR'S SIGNATURE: Wm. J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02517 CERTIFICATE OF DEATH

Reg. Dist. No. 02517

1. PLACE OF DEATH
a. COUNTY: A A Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 226 Arden Road.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
d. STREET ADDRESS: 226 Arden Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: James — Middle: W. — Last: Logan

4. DATE OF DEATH: Month: 3 — Day: 15 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-28-1888
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Bethlehem Co
11. BIRTHPLACE (State or foreign country): Baltimore. Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ✓ (If yes, give war or dates of service): ✓
16. SOCIAL SECURITY NO.: ✓
17. INFORMANT: Mrs. Katie Logan — Address: 226 Arden Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): sudden cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive myocardial mentis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-5, 1957, to 3-15, 1957, that I last saw the deceased alive on 3-14, 1957, and that death occurred at 8:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Eugene Schwitzer M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 3-15-57

PHYSICIAN'S NAME (Type): Eugene Schwitzer, M.D. 3904 S. Hanover St.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/19/57
22c. NAME OF CEMETERY OR CREMATORY: Old Cathedral Cem
22d. LOCATION (City, town, or county) (State): 4300 Old Frederick Road

23. FUNERAL DIRECTOR'S SIGNATURE: Robert E. Cowan & Son — ADDRESS: 90 Hollins St
24a. REC'D BY REGISTRAR DATE: MAR 18 1957
24b. REGISTRAR'S SIGNATURE: Ada Whitson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2474 CERTIFICATE OF DEATH

02518
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis R.F.D. 3
d. STREET ADDRESS: 1st Melvin Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith Middle Davis Last Redue

4. DATE OF DEATH: Month 3 Day 15 Year 1957

5. SEX: Female
6. COLOR OR RACE: Mulatto
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 22-1879
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles T. [redacted] Davis
14. MOTHER'S MAIDEN NAME: Edith Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry C Redue — Address: 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 17 days
DUE TO
331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prostate (enlarged) Thrombosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 26, 1957, to March 15, 1957, that I last saw the deceased alive on March 14, 1957, and that death occurred at 5 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice Klawans M.D. — ADDRESS (Street, city or town, state): 31 Southgate Ave Annapolis, Md. — DATE SIGNED: 3/17/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-18-57
22c. NAME OF CEMETERY OR CREMATORY: London Park
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Tayla Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 19 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02519

02518 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mos.5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3V01-4
d. STREET ADDRESS: 1606 John Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Richard — Middle Garfield — Last Richardson

4. DATE OF DEATH: Month 3 — Day 13 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/14/83

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Maryland9

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: William Henry Richardson

14. MOTHER'S MAIDEN NAME: Rachel Rollins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

434.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Kidney Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/8, 1957, to 3/13, 1957, that I last saw the deceased alive on 3/13, 1957, and that death occurred at 5:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Benedict M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 3/14/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/18/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Memorial Gardens

22d. LOCATION (City, town, or county) (State): Arlington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R. Williams

ADDRESS: 322 N. Schroeder St.

24a. REC'D BY REGISTRAR DATE: MAR 18 1957

24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02519

CERTIFICATE OF DEATH

Reg. Dist. No. 02580

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1yr.5mos.13days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3v01-4
d. STREET ADDRESS: 2834 Westwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: Sanders

4. DATE OF DEATH: Month: 3 — Day: 11 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unk. July-1-1912

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Unknown Cooking Soudus

14. MOTHER'S MAIDEN NAME: Molly Sanders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hosp. Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

434.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/26, 1955, to 3/11, 1957, that I last saw the deceased alive on 3/11, 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 3/12/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/16/57

22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary

22d. LOCATION (City, town, or county) (State): Brooklyn Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. O. Wilson — ADDRESS: 1000 Brantly Ave

24a. REC'D BY REGISTRAR DATE: 3/21/57

24b. REGISTRAR'S SIGNATURE: A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2475

CERTIFICATE OF DEATH

Item 13 FilmC213 4-12-57 et

02521

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY a a — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

LENGTH OF STAY (In this place) 3 hrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY AA

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Louise (Middle) Gross Waters (Last) Scott

4. DATE OF DEATH (Month) 3 (Day) 29 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Colored	Married	Sept 7 1890	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
oyster Shucker	Sea food	Cumberstone Md	

13. FATHER'S NAME: Crowner Thomas

14. MOTHER'S MAIDEN NAME: alice Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		220-16-4990	Raywood Fountain Galesville Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis & hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-27-57, 19..., to 3-29-57, 19..., that I last saw the deceased alive on 3-29, 19 57, and that death occurred at 12 30 M, from the causes and on the date stated above.

SIGNATURE M.D. — ADDRESS (Street, city, town, state) 6 E Cathedral St — DATE SIGNED 4-1-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/1/57	Crowners	Galesville Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
4/3/57	[illegible]	Bernard Hardesty Galesville Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2476 CERTIFICATE OF DEATH

02522
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis (RURAL)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Best Gate Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis (RURAL) X1
d. STREET ADDRESS: Best Gate Road 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First IDA Middle VIRGINIA Last SEARS

4. DATE OF DEATH: Month MARCH Day 11 Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 8, 1867
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): CALVERT Co. MD.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: VIRGINIA KING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Address: Miss Sadie E. Sears #7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: about 2 hrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cr. Myocarditis & fibrositis — INTERVAL: several yrs

DUE TO (c): General Arteriosclerosis — INTERVAL: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mch 11 1957, to Mch 11 1957, that I last saw the deceased alive on Mch 11 1957, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. ADDRESS (Street, city or town, state): Annapolis Md DATE SIGNED: 3-12-57

PHYSICIAN'S NAME (Type): J. OLIVER PURVIS

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: MAR. 14 1957
22c. NAME OF CEMETERY OR CREMATORY: EDWARDS CHAPEL
22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John M. Taylor Son Annapolis Md
24a. REC'D BY REGISTRAR DATE 3/13/57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG212 3-15-57 et

02520

CERTIFICATE OF DEATH

Reg. Dist. No. 02523

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paradise Beach
c. LENGTH OF STAY IN 1b: 13 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 306 Potomac Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paradise Beach
d. STREET ADDRESS: 306 Potomac Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia — Middle: May — Last: Shanahan

4. DATE OF DEATH: Month: March — Day: 7 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1894

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): W. Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Hawk

14. MOTHER'S MAIDEN NAME: Alice Lancaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 216-09-0124

17. INFORMANT: Wm. Shanahan — Address: 306 Potomac Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular disease — 7 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Shaking palsy — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 20, 1950, to March 7, 1957, that I last saw the deceased alive on March 7, 1957, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin, M.D. — ADDRESS (Street, city or town, state): Mountain Road, Pasadena, Md. — DATE SIGNED: March 7, 1957

PHYSICIAN'S NAME (Type): R. M. McLaughlin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-11-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
22d. LOCATION (City, town, or county): Baltimore (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George F. Schwab — ADDRESS: 2101 Frederick Ave.

24a. REC'D BY REGISTRAR DATE: MAR 11 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dalby

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02521 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02524 Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: ~~Prince Georges~~ Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
c. LENGTH OF STAY IN 1b: 9 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S.Route 301

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Prince Georges~~ Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Gambrills
d. STREET ADDRESS: 1 U.S.Route 301
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Lewis Middle: Lyle Last: Simmons
4. DATE OF DEATH: Month: March Day: 31 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 5, 1906
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Part owner
10b. KIND OF BUSINESS OR INDUSTRY: ~~Automobile Dealer~~ (Farm Implement Store:)
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Walter Simmons
14. MOTHER'S MAIDEN NAME: Lillie ~~Boyce~~ Boice Bowers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212 14 93 94
17. INFORMANT: Clara Ina Simmons; Same address — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
442X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: John T. Maloney M.D. — CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X] — DATE SIGNED
EXAMINER'S NAME (Type): John T. Maloney, M.D. — March 31, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/3/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Ritchie Bros. Funeral Home — ADDRESS: Upper Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: APR 4 1957
24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [illegible] Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02525

02522 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Calvert

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 11mos.7days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelina 04x02 ✓

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

d. STREET ADDRESS: Not given

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Virgil Middle: Lost: Sims

4. DATE OF DEATH: Month: 3 Day: 17 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 75? yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Wally Sims

14. MOTHER'S MAIDEN NAME: Virgil Sims

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

490x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/10, 1956, to 3/17, 1957, that I last saw the deceased alive on 3/17, 1957, and that death occurred at 10:20a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 3/18/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF: 3/20/57 — 22c. NAME OF CEMETERY OR CREMATORY: Carrolls Cemetery — 22d. LOCATION (City, town, or county) (State): Baston, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. E. Sewell — ADDRESS: Prince Frederick

24a. REC'D BY REGISTRAR DATE: Mar 18 57 — 24b. REGISTRAR'S SIGNATURE: K. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Singleton

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2477

02526

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Jessup
d. STREET ADDRESS: Box 378 Orchard Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gary — Middle L — Last Singleton

4. DATE OF DEATH: Month March — Day 23 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 16, 1957

9. AGE (In years last birthday): —

IF UNDER 1 YEAR: Months —; Days 7
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roscoe Singleton

14. MOTHER'S MAIDEN NAME: Eleanor Moon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): — — — —

16. SOCIAL SECURITY NO.: — — —

17. INFORMANT — Address: Roscoe Singleton- Father- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Purulent Meningitis - (Coliform bacilli) — INTERVAL BETWEEN ONSET AND DEATH: 2 days
340.3
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-16, 1957, to 3-23, 1957, that I last saw the deceased alive on 3-22, 1957, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward J Skerritt M.D. — ADDRESS (Street, city or town, state): Gambrills Md — DATE SIGNED: 3-23-57

PHYSICIAN'S NAME (Type): Edward Skerritt M.D — Gambrills, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-25-57

22c. NAME OF CEMETERY OR CREMATORY: Glen Hazen Cemetery

22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. French — ADDRESS: Hopping Funeral Home Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 27 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2163399XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2478

CERTIFICATE OF DEATH

02527

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 6 Dowsey Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET — Middle: — Last: SMITH

4. DATE OF DEATH: Month: 3 — Day: 17 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-1-1871

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months: — Days: — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Bias

14. MOTHER'S MAIDEN NAME: Catherine Lusby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Jesse B. Smith — Address: 6 Dowsey Ave. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cerebral Hemorrhage
DUE TO (c): Arterio Sclerotic Hypertensive Cardiovascular Disease

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 19, 1957, to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St. Annapolis, Md. — DATE SIGNED: 3/18/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3-21-57 — 22c. NAME OF CEMETERY OR CREMATORY: St. Anne — 22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese T. — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 20 1957 — 24b. REGISTRAR'S SIGNATURE: Wm. J. French

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02523 **CERTIFICATE OF DEATH** 02528

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 yr. 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 108 Elizabeth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Henry; Middle: ; Last: Stewart

4. DATE OF DEATH: Month: 3; Day: 8; Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 74? yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Walker Gaulker

14. MOTHER'S MAIDEN NAME: Mattie Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hosp. Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Occlusion
DUE TO
(c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/17, 1956, to 3/8, 1957, that I last saw the deceased alive on 3/7, 1957, and that death occurred at 8:23a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 3/8/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 3/10/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles B. Lewis
ADDRESS: 1639 N. Broadway

24a. REC'D BY REGISTRAR DATE: 3/11/57
24b. REGISTRAR'S SIGNATURE: K. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02529

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): ANNE ARUNDEL GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore Maryland
d. STREET ADDRESS: 611 S. Grundy St — 3 Vol-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: E — Last: Steel

4. DATE OF DEATH: Month: 3 — Day: 29 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 15, 1890

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: PAINTER

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH STEEL

14. MOTHER'S MAIDEN NAME: ANNA MORAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES. (If yes, give war or dates of service): WORD WAR I

16. SOCIAL SECURITY NO.: 218-07-4075

17. INFORMANT: ANNA MAE STEEL — Address: 611 S. GRUNDY ST. BALTO. 24, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: Sud Den
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/29/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4-1-57.
22c. NAME OF CEMETERY OR CREMATORY: PARKWOOD CEM.
22d. LOCATION (City, town, or county) (State): TAYLOR AVE., BALTO. Co., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles S. Zeiler
ADDRESS: 901 S. CONKLIN & ST. BALTO., 24, MD.

24a. REC'D BY REGISTRAR DATE: 4/1/57
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2480

CERTIFICATE OF DEATH

02530

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A A. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 157 Prince George
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ellen — Middle: — Last: Strain

4. DATE OF DEATH: Month: 3 — Day: 29 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): About 73 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Earl A. Strain — Address: Elkridge 27 Md

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	3 days
DUE TO (b)	Pelvic peritonitis	6 days
DUE TO (c)	Pyocolpus	7 days

624x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Adenocarcinoma uterus fundus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 —

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/21, 1957, to 3/29, 1957, that I last saw the deceased alive on 3/29, 1957, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Hedeman M.D. — ADDRESS (Street, city or town, state): Cathedral & Annapolis Md — DATE SIGNED: 3/29/57

PHYSICIAN'S NAME (Type): John Hedeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 4-1-57 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem — 22d. LOCATION (City, town, or county): Pikesville Highway (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Hayle Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 4/1/57 — 24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02531

2482

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 304 Melvin Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Prince William
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nokesville 83K-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Victoria Middle Lee Last Sturgill

4. DATE OF DEATH: Month March Day 9 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: May 26, 1877
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Robbins
14. MOTHER'S MAIDEN NAME: Francis Kennel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Fern Nicholson-Daughter- Address: 304 Melvin Ave. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Inanition	4 Days.
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Vascular Accident	3 mos
DUE TO (c)	Cerebral Arteriosclerosis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 20, 1957, to 9 Mar, 1957, that I last saw the deceased alive on 9 Mar, 1957, and that death occurred at 4:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D.
ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type): Edward S. Beck M.D. Southgate Ave. Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 12, 57
22c. NAME OF CEMETERY OR CREMATORY: Stonewall Mem. Gardens
22d. LOCATION (City, town, or county) (State): Manassas, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAR 11 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be signed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02532

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jacobsville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Same
d. STREET ADDRESS: / Same
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Noah — Middle: Harem — Last: Sylvester

4. DATE OF DEATH: Month: March — Day: 18th — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 7/27/11

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber helper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Brunswick, Georgia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Marine

16. SOCIAL SECURITY NO.: 718-09-5501

17. INFORMANT — Address: Mrs. Janet Sylvester (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic alcoholism — INTERVAL BETWEEN ONSET AND DEATH:

581.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Fatty infiltration of liver

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: William V. Lovitt Jr. M.D.

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]

DATE SIGNED: 3/19/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: March 20/57 — 22c. NAME OF CEMETERY OR CREMATORY: Glen Haven — 22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Richard L. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: March 21, 57

24b. REGISTRAR'S SIGNATURE: L J Dalba

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG214 4-18-57 et

02525

CERTIFICATE OF DEATH

02533

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Brooklyn
d. STREET ADDRESS: 1 4304 Third
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Eva Middle T. Last Thomas

4. DATE OF DEATH: Month March Day 23 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 26 1888
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Penn Grove
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Leage Sparkes
14. MOTHER'S MAIDEN NAME: Dant Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: William F. Thomas Jr. Address: 4304 Third St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio-vascular — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO (b): Renal Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized arterio-sclerosis — 4 years

442 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus Duration (?)

260 x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/20, 1953 to March 23, 1957, that I last saw the deceased alive on March 23, 1957, and that death occurred at 7.20 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Deibel, M.D. — ADDRESS (Street, city or town, state): 1226 Hanover St. — DATE SIGNED: 3/23/57

PHYSICIAN'S NAME (Type): HARRY DEIBEL, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 26/1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): A.A. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. L. Brown (Evans) — ADDRESS: 140 S. Charles St
24a. RECD BY REGISTRAR DATE: MAR 26 1957
24b. REGISTRAR'S SIGNATURE: Ida Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2483

02534

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Truxton Hgts
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SELMA — Middle — Last TUCKER

4. DATE OF DEATH: Month March — Day 20 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 17, 1874

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Mobile, Alabama

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 418-01-1116F

17. INFORMANT — Address: Mrs Lula B. Posey- Daughter- Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. p. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/20, 1957, to 3/20, 1957, that I last saw the deceased alive on 3/20, 1957, and that death occurred at 5:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John R. Hedeman M.D.

ADDRESS (Street, city or town, state): 90 Catherdral St. Annapolis, Md.

DATE SIGNED: 3/21/57

PHYSICIAN'S NAME (Type): John R Hedeman M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial

22b. DATE THEREOF: 3-24-57

22c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

22d. LOCATION (City, town, or county) (State): Bessemer, Jefferson Co., Alabama

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME

ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 22 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be d... for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 sho... filed with the registrar prior to ...rial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

02526

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02535

Reg. Dist. No. 21

Items 8&17 Film G212 3/19/57 GTE

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bay Ridge
c. LENGTH OF STAY IN 1b: 20 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Bay Ridge
d. STREET ADDRESS: 43 Bay Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE — Middle LEE — Last WARD

4. DATE OF DEATH: Month March — Day 13 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 13, 1875

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oxon Hill, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Spencer

14. MOTHER'S MAIDEN NAME: Anne Schaaf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT H. Address: John M. Joynt, 1401 K St NW, Washington DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Prolly, 19 55, to March 13, 19 57, that I last saw the deceased alive on March 7, 19 57, and that death occurred at 7 30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John M. Hedrwen M.D. — ADDRESS (Street, city or town, state): 90 Cathedral St. Annapolis, Md. — DATE SIGNED: March 13, 1957

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3/16/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: 1756 Pennsylvania, Ave NW, Washington, DC

24a. REC'D BY REGISTRAR DATE: MAR 15 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02536

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 40 y.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): On pavement inback of home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2. Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert Middle C. Last Ward

4. DATE OF DEATH: Month March Day 26th. Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate Agent
10b. KIND OF BUSINESS OR INDUSTRY: U.F.Federal & Loan
11. BIRTHPLACE (State or foreign country): 10/20/83
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas S.Ward
14. MOTHER'S MAIDEN NAME: Mary A. Coulbourn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes I WW.
16. SOCIAL SECURITY NO.: 213-22-0269
17. INFORMANT Address: Mrs. Ethel T.Ward,(wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular diseases — 2 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell on the cement walk.
20c. TIME OF INJURY Hour a. m. / p. m. 4.50 — Month, Day, Year 3/26/57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): In the back yard
20f. (City or town) of home. Glen Burnie (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3/28/57
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 29/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Brooklyn RFD, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R F Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: March 31, 1957
24b. REGISTRAR'S SIGNATURE: L J D'Alba

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 0212 3-22-57 et

02528

CERTIFICATE OF DEATH

Reg. Dist. No. 025378

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 Vol-4
d. STREET ADDRESS: 631 Portland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Florence Middle McClelland Last Watson
4. DATE OF DEATH: Month 3 Day 1 Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Negro	NEVER MARRIED ☒	Not given	25? yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unk.	Unk.	Unk.	Unk.

13. FATHER'S NAME: Unk.
14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Unk.	Unk.	Unk.	Hospital Records	Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

490 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocardial Degeneration

DUE TO (c): Catatonic Schizophrenia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 2/17, 1957, to 3/1, 1957, that I last saw the deceased alive on 3/28, 1957, and that death occurred at 6:40a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 3/1/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/5/57	Mount Calvary	Brooklyn, A.A. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Elroy O. Wilson 1000 Brantley Ave.

24a. REC'D BY REGISTRAR DATE: 3/8/57

24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2481 **CERTIFICATE OF DEATH**

03666 21

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1805 Robert Small Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 1805 Robert Small Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Stanley Middle Lost Watson

4. DATE OF DEATH Month 3 Day 25 Year 1957

5. SEX Male

6. COLOR OR RACE Col

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 12-22-56

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR Months 3 Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Lee Character

14. MOTHER'S MAIDEN NAME Lorena Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Manuel Turner Address Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH 1 day.

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-25, 19 57, to —, 19 —, that I last saw the deceased alive on 3-25, 19 57, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Faye Allen M.D. ADDRESS (Street, city or town, state) 62 Cathedral DATE SIGNED 3-26-57

PHYSICIAN'S NAME (Type) Faye W. Allen 62 Cathedral St 3-26-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 3-27-57

22c. NAME OF CEMETERY OR CREMATORY Brewer Hill

22d. LOCATION (City, town, or county) (State) Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Annapolis, Md.

24a. RECD BY REGISTRAR DATE APR 1 0 1957

24b. REGISTRAR'S SIGNATURE Jm J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02538

02529 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold Md
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Arnold Md.
d. STREET ADDRESS: 1 Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rachel — Middle: Catherine — Last: Watts

4. DATE OF DEATH: Month: 3 — Day: 27 — Year: 1957

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/19/1915

9. AGE (In years last birthday): 42 yrs.

IF UNDER 1 YEAR: Months: 7 — Days: 8 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Arnold

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Woods

14. MOTHER'S MAIDEN NAME: Louise Hentsman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Samuel Watts — Address: Arnold Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
600.0
DUE TO (b): Chronic Pyelonephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 14, 1957 to March 27, 1957, that I last saw the deceased alive on March 27, 1957, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.L. Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St Annapolis, Md. — DATE SIGNED: 3/29/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b.** DATE THEREOF: 3/31/57 — **22c.** NAME OF CEMETERY OR CREMATORY: Mt. Calvary — **22d.** LOCATION (City, town, or county) (State): Arnold Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ethel B. Hicks — ADDRESS: 113 Northwest St Annapolis Md

24a. REC'D BY REGISTRAR DATE: APR 1 1957 — **24b.** REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02539

CERTIFICATE OF DEATH

02539 Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVIERA BEACH
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WANDA ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo RIVIERA BEACH
d. STREET ADDRESS: 1 WANDA ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SYLVIA Middle — Last WEBER

4. DATE OF DEATH: Month MARCH Day 13 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: AUG. 31 1893

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ROBERT GANZHORN

14. MOTHER'S MAIDEN NAME: ELIZABETH MAGINNY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MRS DORA MAE WILLIAMS — SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

153X

DUE TO (b): General Metastasis to abominal

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Mesentary and liver -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hyperatrophic arthritis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-3, 19 57, to 3-13, 19 57, that I last saw the deceased alive on 3-10-57, 19, and that death occurred at 8:35 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A Cais M.D. — ADDRESS (Street, city or town, state): 4N. Fulton Ave Balto Md — DATE SIGNED: 3/13/57

PHYSICIAN'S NAME (Type): A CAIAS — 4N - Fulton Ave Balto Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MARCH 16, 1957

22c. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL

22d. LOCATION (City, town, or county) (State): BALTIMORE, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Geo J. Force — ADDRESS: 4001 RITCHIE HWY

24a. REC'D BY REGISTRAR DATE: 3/26/57

24b. REGISTRAR'S SIGNATURE: L. J. Dalby

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02531 **CERTIFICATE OF DEATH** 02540

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: 2yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 205 Rt. 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Xo Severn
d. STREET ADDRESS: Box 205 Rt. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ESTHER Middle Last WEST

4. DATE OF DEATH: Month March Day 3, Year 1957

5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 3,1888
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Keysville Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sidney Johnson
14. MOTHER'S MAIDEN NAME: Annie Bolden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Elizabeth Casey Address: Box 205 Rt. 2 Severn Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO (b): Acute Cerebral Thrombosis — 3 days
DUE TO (c): Senility

490X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 26- 57, to March, 57, that I last saw the deceased alive on March 3- 57, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Lipsky M.D. ADDRESS (Street, city or town, state): Odenton Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Joseph Lipsky

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.6,1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R. Williams ADDRESS: 322 N. Schroeder St.
24a. REC'D BY REGISTRAR DATE: 3/8/57
24b. REGISTRAR'S SIGNATURE: Clara Harlow

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2484 **CERTIFICATE OF DEATH**

02541 Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Annapolis
c. LENGTH OF STAY IN 1b: 2 Hrs 40 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V 0 1 - 4
d. STREET ADDRESS: 2000 Crestview Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Jay — Last: WHITE

4. DATE OF DEATH: Month: March — Day: 26 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-15-89

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Physician

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Arthur WHITE

14. MOTHER'S MAIDEN NAME: Florence BOWMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1917-1947

16. SOCIAL SECURITY NO.: 578-44-2645

17. INFORMANT: USNH RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction, Myocardium — INTERVAL BETWEEN ONSET AND DEATH: 7½ hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 March, 1957, to 26 March, 1957, that I last saw the deceased alive on 26 March, 1957, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): R. K. MOXON, CDR, MC, USN — 26 March 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 1, 57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping Funeral Hoem, Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 29 1957

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02532 **CERTIFICATE OF DEATH**

02542
Reg. Dist. No. 20

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover
c. LENGTH OF STAY IN 1b 11 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Edward Middle J. Last White

4. DATE OF DEATH Month 3 Day 14 Year 1957

5. SEX Male

6. COLOR OR RACE Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7-20-1888

9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor

10b. KIND OF BUSINESS OR INDUSTRY A.A.Co.Bd. Education

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas White

14. MOTHER'S MAIDEN NAME Ida White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 1918

16. SOCIAL SECURITY NO.

17. INFORMANT Address
Faith L. White - Edgewater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO 434.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-14-54, 19____, to 3-14-57, 19____, that I last saw the deceased alive on 3-11-57, 19____, and that death occurred at 9?? M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.

ADDRESS (Street, city or town, state) Cockeysville

DATE SIGNED 3-15-57

PHYSICIAN'S NAME (Type) A T ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 3-17-57

22c. NAME OF CEMETERY OR CREMATORY Macedonia

22d. LOCATION (City, town, or county) (State) Davey Quarter, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Lease & Son

ADDRESS Annapolis, Md.

24a. REC'D BY REGISTRAR DATE MAR 19 1957

24b. REGISTRAR'S SIGNATURE Carrie Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02534 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02544
Reg. Dist. No.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bay Ridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sands Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bay Ridge
d. STREET ADDRESS: 1 Sands Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Majorie — Middle: C. — Last: Wilhelmson

4. DATE OF DEATH: Month: March — Day: 5 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 23, 1923

9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: "Unk"

14. MOTHER'S MAIDEN NAME: "Unk"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Berthil E. Wilhelmson — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 976X
DUE TO (b): Fractured Skull
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Left wheeled wand

20c. TIME OF INJURY: Hour: a. m. — Month, Day, Year: 3 5 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Arco (County): MD (State):

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. L. Winhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/5/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-8-1957
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county): Prince George Co (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layfield Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 3/7/57
24b. REGISTRAR'S SIGNATURE: [signature]

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02533 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02543

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bay Ridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sands Point Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bay Ridge
d. STREET ADDRESS: 1 Sands Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Curt — Middle: Evans — Last: Wilhelmson

4. DATE OF DEATH: Month: March — Day: 5 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 18, 1956

9. AGE (In years last birthday): yrs. 3 — IF UNDER 1 YEAR: Months 3, Days 13 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Berthil E. Wilhelmson

14. MOTHER'S MAIDEN NAME: Majorie Cumming

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Berthil E. Wilhelmson — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot Wound Chest — INTERVAL BETWEEN ONSET AND DEATH: Instan
DUE TO (b):
DUE TO (c):

981X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. — Month, Day, Year: 3 3 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autapsy ☐, Inspectian ☐, Inquiry ☐, and find that deoth resulted from: Notural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined couse ☐.

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. F. Weichardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/7/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 3-8-1957

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or county) (State): Prince George Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 8/7/57

24b. REGISTRAR'S SIGNATURE: [signature] - D. Council

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

2046 321 XV5

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02535

02545 28
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5yrs. 43days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3Y01-4
d. STREET ADDRESS: 2434 Druid Hill Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Joseph — Middle Alexander — Last Wilson

4. DATE OF DEATH: Month 3 — Day 7 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/6/17

9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Wilson

14. MOTHER'S MAIDEN NAME: Mary Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records
Address: Crownsville State Hosp. Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypostatic Pneumonia

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Respiratory failure and cardiac failure secondary to Cerebral Vas-

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of 18.): -ular Accident

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/23, 19 52 to 3/7, 19 57, that I last saw the deceased alive on 3/7, 19 57, and that death occurred at 4:45p.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 3/8/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)

22b. DATE THEREOF: 3/11/57

22c. NAME OF CEMETERY OR CREMATORY: National Cemetery

22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Holland Funeral Home Balti. Md

ADDRESS

24a. REC'D BY REGISTRAR DATE: MAR 11 1957

24b. REGISTRAR'S SIGNATURE: E. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02546

Reg. Dist. No. 7-1

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Donaldson Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Severn
d. STREET ADDRESS: 1 Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leroy Herbert — Middle: Wolf — Last:

4. DATE OF DEATH: Month: March — Day: 5th — Year: 19 57

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/2 6/17

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Shipyard

11. BIRTHPLACE (State or foreign country): Landsdown, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herbert Wolf

14. MOTHER'S MAIDEN NAME: Lucy Donaldson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 418-07-1224

17. INFORMANT: Mrs. L.H.Wolf, Address: Severn, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage due to fracture of skull caused — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): by self inflicted injury with a double barrel

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X

DUE TO (c): twelve gauge shot gun — Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental troubles.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted injury with a gun.

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 9.15 A.M. 19 3/5/57

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Severn (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3/6/57

EXAMINER'S NAME (Type): Gus tave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/8/57

22c. NAME OF CEMETERY OR CREMATORY: Friendship

22d. LOCATION (City, town, or county) (State): Anne Arundel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James A. Hopkins

ADDRESS: Hopping and Hopkins, Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: MAR 8 1957

24b. REGISTRAR'S SIGNATURE: Clara Hastings

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G212 3-19-57 et

02537

CERTIFICATE OF DEATH

02547

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6yrs.10mo.20day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 Vol-4
d. STREET ADDRESS: 1803 Walbrook Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Eugene; Middle; Last Wright

4. DATE OF DEATH: Month 3; Day 9; Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/2/78 8-2-82

9. AGE (In years last birthday): 74/78 yrs.
IF UNDER 1 YEAR: Months 74; Days _
IF UNDER 24 HRS.: Hours _ Min. _

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Wright

14. MOTHER'S MAIDEN NAME: Alice Janor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hosp. Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular Disease — 422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/17, 1950, to 3/9, 1957, that I last saw the deceased alive on 3/9, 1957, and that death occurred at 11:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ludwig Benedict M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 3/10/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/13/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
22d. LOCATION (City, town, or county) (State): Baltimore City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

24a. RECD BY REGISTRAR DATE: MAR 12 1957
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2435 Item 9 FilmG212 3-13-57 et

CERTIFICATE OF DEATH

02548 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S.Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rural Annapolis
d. STREET ADDRESS: Box#112 Rt.#2 Edgewater,Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Denton — Middle: Ray — Last: ZEPP
4. DATE OF DEATH: Month: March — Day: 6 — Year: 1957

5. SEX: M
6. COLOR OR RACE: Cau.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 17 May 1894
9. AGE (In years last birthday): 62 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USN RET
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Windsor Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1912-1928
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: U.S.Naval Hospital,Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombosis Coronary Artery left,anterior descending,branch of. — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-6, 1957, to 3-6-, 1957, that I last saw the deceased alive on 3-6-57, 1957, and that death occurred at 12:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): U.S.Naval Hospital, Annapolis,Md.
DATE SIGNED: 3-6-57
PHYSICIAN'S NAME (Type): R.K. MOXON CDR MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-8-57
22c. NAME OF CEMETERY OR CREMATORY: St. James
22d. LOCATION (City, town, or county) (State): Tracey Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son
ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: 3/7/57
24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02549

02538 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anna Arundell County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 Camp Mead Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthycum Heights
d. STREET ADDRESS 801 Camp Mead Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Lillian Middle (Kmieciak) Last Ziemba

4. DATE OF DEATH Month March Day 14 Year 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sep. 14 1906

9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Aleksander Chojnowski

14. MOTHER'S MAIDEN NAME Josephine Walczuk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address 240 North
Mrs. Anna Pilachowski Aunt Milton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of uterus — INTERVAL BETWEEN ONSET AND DEATH 1 2 yrs

174X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1956, to March 14, 1957, that I last saw the deceased alive on March 8, 1957, and that death occurred at 3 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE C. Milton Linthicum M.D. ADDRESS (Street, city or town, state) 106 W. Ripple Rd Linthicum Hgts DATE SIGNED 3/15/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF March 18 1957

22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.

22d. LOCATION (City, town, or county) (State) German Hill Road Balto. County

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John M. Weber 401 S. Chester Street

24a. REC'D BY REGISTRAR DATE MAR 15 '57

24b. REGISTRAR'S SIGNATURE W. Fedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

MAR 18 1957

BUREAU V. S.